

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011799	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/24/2015
NAME OF PROVIDER OR SUPPLIER GREENBRIAR VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8800 SPOON DR INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00184454 and IN00186247.</p> <p>Complaint IN00184454-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00186247-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey Dates: November 23 and 24, 2015</p> <p>Facility number: 011799 Provider number: 011799 AIM number: N/A</p> <p>Census bed type: Residential: 110 Total: 110</p> <p>Census payor type: Medicaid: 29 Other: 81 Total: 110</p> <p>Sample: 3</p> <p>Greenbriar Village was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00184454 and IN00186247.</p> <p>Quality review completed by 30576 on November 25, 2015</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE